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Destiny Care Support

Inspection report

Crowhurst Care Home
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East Sussex
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Destiny Care Support is a supported living service providing personal care to seven people with a learning disability at the time of the inspection. The service can support a maximum of 10 people. The service is located in a large residential building set on a quiet rural lane.

People's experience of using this service and what we found
People had not been protected from the risk of harm. Risks to people from the environment had not been safely managed. People had a range of health needs such as around choking and fluid intake but these were not being managed safely.

Staff had not been recruited safely. We asked the provider to take immediate action to provide assurance that all staff working at Destiny Care Support had the necessary checks and suitability to work at the service.

Staff did not have the skills and competencies to carry out their role. For example, one person at risk of choking needed staff that were trained in dysphagia [swallowing difficulties] but no staff working at the service had this. Staff had not had regular supervision or appraisals. People were not having their fluid levels monitored effectively.

People were not being supported to maximise their independence. For example, staff had been writing people's care plans and writing the menu. People told us they were not involved in cooking their main meal, despite some people being interested in cookery.

People did not have goals or plans to learn new skills in place. People with communication needs did not have visual planners when these could help them. Activities for people were not person centred.

The provider did not have sufficient oversight of the service and governance systems were not effective in driving improvement. There was no manager registered with CQC in day to day control of the service, as they had left at short notice prior to our inspection.

People had mental capacity assessments and where necessary best interest decisions were made where people lacked capacity. The policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability

the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

People had been protected from abuse and staff understood their role in safeguarding people. People told us they liked the staff and were happy living at Destiny Care Support.

Right support:
• The model of care and setting did not always maximise the choice people had, and peoples independence was not enhanced.
• The provider's office where they managed the support from was located in the same main building as people's rented accommodation. This may make it difficult for people to choose support from another provider, although their tenancy allows this.
• People did not have identified goals and aspirations and staff did not consistently support people to achieve greater confidence and independence. The service had not routinely sought paid or voluntary work, leisure activities and widening of social circles.
• The service was located in a rural setting on a secluded lane and accessing the community often required staff support, which meant some people had to wait to access activities or shopping. Other people could access the community independently via taxis or local transport links.

Right care:
• Care was not person-centred and had failed to promote people's dignity and human rights.
• People did not always receive their care in a way that empowered them or promoted their independence.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives.
• The provider had not been alert to the culture within the service and had not spent enough time with staff and people and discussing behaviours and values.
• The culture in the service was not always positive. Staff told us that morale was low and they were unable to say what the vision and values of the service were.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 11 November 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found not enough improvements had been made and the provider remained in breach of regulations.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about the environment and the fitting of specialist equipment. A decision was made for us to inspect and examine those risks.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to, person centred care, safe care and treatment, good governance, staffing and notifying CQC of significant events at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Destiny Care Support

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two Inspectors, and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in one 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.
The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We reviewed recent safeguarding incidents and spoke to professionals involved in the service. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and three relatives about their experience of the care provided. We communicated verbally with four people during face to face informal chats in their home. We spoke with five members of staff including support staff, agency staff and live in staff.

We reviewed a range of records. This included four people's care records and five medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, and learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to improve the way they managed risks associated with choking and other health conditions. Not enough improvement had been made and the provider is still in breach of Regulation 12.

• The service had not ensured that people were protected from the risk of harm. Prior to our inspection we were told about the fitting of specialist equipment by an untrained person, which exposed people to serious risk of harm.
• A person using the service was at risk of consuming non-food items. We found a storage room on the first floor near people's bedrooms that was unlocked and had bleach and drain cleaner in it. This was unsafe and we raised this with the provider who had subsequently ensured this door was kept locked.
• Risks to people from choking had not been managed adequately. One person had a care plan and risk assessment that outlined a need for measures to be in place, such as staff being in the room as they ate, to ensure the person was safe from choking risks. This support was not in place during our inspection and care plans had not been updated to direct staff on the actions to take. We raised this with the provider and asked for action to be taken to reduce the risk.
• One person had a known medical condition that meant they should have their fluid intake monitored but there was no guidance around what a safe level of fluid intake was for that person. Staff we spoke with were unable to tell us what would be unsafe for the person. Following our inspection, the provider contacted the person's GP for clarification.
• One person had been experiencing seizures, that were not related to epilepsy. However, there was no guidance on how staff should support them during and after a seizure. We spoke with staff who told us there was not any guidance and that the person was not wearing a monitor as described in their risk assessments. We raised this with the provider who put in place guidance and updated care plan.
• Lessons were not being effectively learned from incidents to ensure that risks to people were reduced. Incident reports were not consistently being completed or analysed and some incidents were not being recorded. We asked one staff about a person's emotional distress and where incidents relating to these were recorded. The staff told us, "If you ask [person] what upsets them, they can't remember so it's difficult to write up and its over as quick as it started really. There were ABC charts; I've seen a paper one but not recently and not on the new [electronic] system." ABC charts record what happens before, during and after an incident to allow managers to explore what people are trying to express to reduce the risk of recurrence. The lack of monitoring of behaviours of concern puts people and staff at risk of repeated incidents of

distress.
People had not been kept safe from risks. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• At our last inspection we made a recommendation about the deployment of staff during the day and night-time. This issue had been resolved however, we found other concerns relating to the employment of staff.
• Safe recruitment processes had not been followed for all staff. There were two live-in staff who had recently began working in the service. Neither staff had been interviewed, had an employment history check, had identification checks, neither were references sought, prior to our inspection. This put people at serious risk of harm. Following our inspection, the provider assured us all checks had been completed.
• Staff told us they worried about the lack of permanent staffing. One staff told us, "Sometimes yes, there's not a lot of staff." The provider was using agency staff to cover shifts and had requested the same agency staff to cover multiple shifts.

Preventing and controlling infection
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. PPE was being disposed of in domestic bins and one staff was not wearing a face mask during our inspection. We asked one person whether staff always wore masks and they said, "No not all the time, they don't normally."

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were areas of the premises that were unclean and in need of repair, such as the conservatory and hallway area on the first floor.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Not all visitors had been temperature checked.

● We were somewhat assured that the provider was meeting shielding and social distancing rules, as people had this only verbally explained the provider did not have a system for checking people's understanding.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed as PPE was not consistently used.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
The provider was facilitating visits to the service in line with latest government guidance.

People had not been kept safe from risks. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems to safeguard people were effective which meant that people were not sufficiently protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People told us they knew to speak with staff if they were worried about anything. One person told us, "Yes I feel very safe here." People knew which staff to speak with and were confident staff would take action to protect them.
● Staff understood how to keep people safe from the risk of abuse and had been trained to recognise the signs of abuse in each person. Staff were able to describe to us the different ways a person might react to different types of abuse.
● There was an up to date safeguarding policy that had been reviewed and amended in the last year.

Using medicines safely

At our last inspection the provider had failed to ensure that people had safe access to medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to medicines.

● Following our last inspection, medicines management had been reviewed and improved by the provider. People's medicines were now being kept individually in people's rooms and dispensed in rooms.
● The provider confirmed that they had oversight from the local authority who conducted an audit and were happy with the improvements. People told us that they received their medicines when they needed them, and they were happy to have their medicines in their rooms.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience.

At our last inspection the provider had failed to ensure adequate supervision and training for staff to have the skills and competencies to deliver effective care and support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not addressed issues we found with staff training and supervision. At this inspection not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff did not have the skills and competencies they needed to fulfil their roles effectively. One person's speech and language therapy assessment report highlighted the need for staff to have dysphagia training. However, only two staff had received this and both had recently left the service meaning no staff were trained. This left the person at risk of choking. We asked the provider to address this immediately.
● Induction of new staff was not always effective. Some staff had started working prior to completing their induction and training; this had included lone working at night-time.
● We spoke with one of these staff and they were not aware of all people's needs. For example, they were not able to identify all people with a choking risk or people who were at risk of eating non-food items. This put people at risk from choking. Following our inspection, the provider confirmed that all staff had been fully inducted.
● There had been a lack of supervision and appraisal of staff. Supervisions should be an important formal process between staff and managers where staff can review their workload, monitor and review performance, and identify any learning and development opportunities.
● A supervision planner showed that some permanent staff had only had one supervision, and no appraisal of their performance, in the 12 months prior to our inspection. One staff told us, "Supervisions: yes, perhaps I had 1 or 2 in the last year. I have had appraisals in the past but not recently." This meant that staff may not have a formal place to discuss any issues and any feedback about performance was not shared in a structured way.

The lack of effective supervision and training meant staff did not have the skills and competencies to deliver effective care and support. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet, and supporting people to live healthier lives, access healthcare services and support

At our last inspection we found there were not effective systems to demonstrate health needs were safely managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to address concerns with fluid monitoring and a this inspection not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● People were not having their fluid intakes monitored effectively. One person was living with a health condition and their care plan for this condition stated they should eat a healthy diet and drink 6-8 glasses of water a day. The persons fluid chart showed they had not been receiving this amount and some days their fluid intake had not been recorded.
● A second person needed their fluids monitored on fluid charts for a health condition, but this was not consistently happening. We spoke with staff about this who told us, "We used to have fluid chart but that went by the by." The lack of recording of fluids put people with health conditions at risk.
● During our inspection we observed one person, having to request drinks on two occasions, despite it being a very hot day. Eventually, the provider asked staff to take the person to get their own drink.
● People were not being fully involved in managing their own health. People had not been supported to carry out 'self-checks' of their own bodies to ensure they were in good health. Staff told us that self-checks were not happening but could be put in place for some people. Other people were being seen regularly by their GP for reviews.

We found no evidence people had suffered ill health, dehydration or malnutrition, but there were not effective systems to demonstrate health needs were safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● People told us they liked the food at Destiny Care Support. One person told us, "I like the food, and my favourite is roast dinner, but also, salad, Bolognese, chicken, curries and chilli."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had failed to ensure that consent to care and treatment was being sought in line with legislation. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Following our last inspection the provider had ensured that people had mental capacity assessments where they may lack capacity to make decisions. These were decision specific and where necessary there was a follow up meeting that ensured any decision made was in the person's best interests.

● One person had a preference for how they wanted their food to be prepared. Staff knew about this and respected the person's decision.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had not been clearly assessed in terms of their social, physical and mental needs. As a result, people's care plans did not have effective support outcomes they were working towards.
● Peoples care plans did not consistently identify their needs and staff gave inconsistent information when speaking about people's support needs. We have reported on this in more detail in the Safe section of this report.
● Staff had not ensured people had up-to-date care and support assessments, including medical, psychological, functional, communication, preferences and skills assessments.
● Staff had not completed functional assessments for people who needed them. This meant that staff did not have the information to understand people's distress.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

We last reviewed this key question at our inspection in 2018 when it was rated as Good. At this inspection, this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted positively in the service. We spoke with three people who each told us that staff wrote the meal plan and also cooked the evening meals without involving people.
- People would previously discuss the menu at the house meeting. However, there had not been a house meeting for people who live at Destiny Care Support since July 2021.
- People did not have a skills teaching plan which identified target goals and aspirations and supported them to achieve greater confidence and independence. We asked one permanent staff whether people had skills teaching plans or similar documents and they said, "No I don't think so. I haven't seen any."
- Staff did not support people to access paid or voluntary work, leisure activities or widening of their social circles. People were not being supported to have the opportunity to try new experiences or develop new skills. We reviewed people's weekly planners and some people had very limited experiences, focusing mainly on domestic tasks and occasional day services.

Supporting people to express their views and be involved in making decisions about their care

- People were not always able to express their views and have their opinions respected. One person used to enjoy cooking and being in the kitchen. However, they had not been supported to cook. We asked staff about this and we were told about an incident 'a long time ago'. The person did not have a positive behaviour support plan for their distress, and they had not been supported to find a safe way to be involved with cooking. Staff told us that they thought a support plan may have got lost but confirmed that the person was not being involved in cooking.
- People were not being involved in writing and reviewing their care plans. We spoke with people and staff who confirmed this. One person said, "The staff do it all [write care plans] and type it out on the little tablet." One staff told us, "We used to do monthly reports and information from that helps with some of the care plans, but the monthly reports stopped: I don't know why." We spoke with a second person and asked if they were asked about their care plan. The person said, "No, they [staff] worked it out."

People were not being supported to collaboratively review their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

- We saw people being supported by staff that were caring in their approach. Staff were kind and spoke with people in gentle voices. Staff helped one person to cut their food up when they were struggling to do so.

● People told us they liked staff. One person said, "The staff are nice and kind and helpful. They do our dinners, help us out, and are good to talk to if you have a problem." Another person smiled and gave a thumbs up when we asked if they liked their staff.

● The provider had not followed best practice standards which ensured people received privacy, dignity, choice and independence in their tenancy.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

We last reviewed this key question at our inspection in 2018 when it was rated as Good. At this inspection, this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Because care plans were not person centred, staff were not able to use person-centred planning tools and approaches to achieve goals and aspirations with people. We spoke with one person about goals and they told us, "Probably go on holiday. We haven't been on holiday." The person's care plans did not have any goals or actions to work towards planning and arranging a holiday.
- Staff had not discussed ways of ensuring peoples goals were meaningful and spent time with people understanding how they could be achieved. Staff confirmed that there were no goals in people's care plans and no individualised learning plans.
- Staff had not made reasonable adjustments to ensure better health equality and outcomes for people. This included ensuring people with sensory sensitivities were supported in a way which was comfortable to them.

- Support was sometimes arranged around staff timetables and was not always person centred. For example, we were told one person likes cooking but they did not cook often. One staff told us, "[Name] doesn't do an awful lot as they aren't here at the right time." This meant people did not always have support with certain skills at times that suited them.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There was a lack of assistive communication tools for people that may benefit from them. We spoke with staff about the needs of people. One staff told us, "We had visual charts with [name], but with the other people not really. They used to have it on the wall with pictures of what they were doing: we had it in the past."
- People did not have key care plans in accessible format and didn't read them. One person commented, "I sometimes see my care plan but not that often. I don't know what it says; it's all in different sections."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not being supported by staff to try new things and to develop their skills. We spoke with a

visiting health and social care professional about one person and were told, "The list of activities beyond morning day service was mostly just tagging along for drives, waiting to see family, or going to look at trains."

● One relative told us, "I like [name] to go into the community: the downside is the staff haven't been able to access that much community activity for [name]." One staff said, "We have had [activities] in the past but haven't got them at the moment." There was a whiteboard in the office with people's schedules but these were often blank for whole days, and people had not been supported to plan any weekend activities.

People's care was not designed to achieve their preferences and ensure their needs were met. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One autistic person was supported by permanent staff to engage with a specific interest. The person collected certain things and was supported to use a specific room to listen to their favourite music. Staff were able to speak about the types of music the person listened to.

Improving care quality in response to complaints or concerns

● There was a complaints policy in the service that was available to people in an easy read format. The policy set out a three-stage process for resolving complaints, including who to speak with outside of the organisation if the complaint was not resolved satisfactorily.

End of life care and support

● Nobody at the service was receiving end of life care. People had end of life care plans that were ready to be completed when the time came.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to ensure that quality audits had been effective in making improvements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured audits were effective in improving safety and quality of care. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● At our last inspection we raised concerns around the safe management of risk; safeguarding; the safe management of medicines; consent; the safe management of people's health needs, including fluid intakes; staff training and supervision, and the efficacy of audits and management of the service.
● At this inspection we saw improvements had been made in relation to managing people's consent and safe medicines management. We also saw risks around safeguarding had been reduced as some people had left the service. However, we found continued concerns with the management of risk, safe management of health needs, staff training and supervision and the management and governance of the service.
● At our last inspection we identified six breaches of regulations relating to safe care and treatment, safeguarding, consent, good governance, staffing and submitting statutory notifications to CQC. At this inspection three of the breaches remained and a new breach relating to person centred care was identified.
● We found concerns with people's care plans that were also identified at our last inspection. We asked the provider why these had not been put right. The provider acknowledged this should have been checked after they had been assured it was put right by the previous manager. The provider told us, "For me it's starting afresh to get to know people and understand there's a lot more to be done to ensure people's care plans are more current and complete."
● The provider had only very recently taken over day to day control of the service following the manager leaving. However, they did not know which audits had or had not been completed.
● The provider had not invested sufficiently in the service, embracing change and delivering improvements. Following our inspection we were told by the provider that a programme of works to improve the service were underway.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was not a positive culture in the service. Staff were not able to tell us what the vision and values of

the service were. Staff also told us that there was poor morale in the service following four permanent staff members leaving. One staff told us, "We used to work as a team, so you had someone to bounce off of and talk to, and I find it is different on your own it's not the same as having another member of staff to talk to and its depressed everybody to be honest." Another staff commented, "It used to be such a buzzing busy place but it's gone. They need it back. People are unsettled."

● One person told us that people who lived at Destiny Care Support were not involved in the interviews for new staff. Other people and staff also told us that people living at Destiny Care Support were not informed that new staff would be living in their home.

● The culture had not created a workplace where issues could be formally discussed. Staff confirmed with us that they did not have regular supervisions or team meetings. One person told us about the food at the service, "There is no [menu] choice, the staff make the planner." The same person when asked about the atmosphere in the home said, "Cosy, warm, homely: none of them."

● Quality audits had not been effective in highlighting all concerns we identified at this inspection. The provider had started to audit areas of risk and concern, such as the physical environment. However, this should have already been happening and in place, as part of the responsibilities as a registered provider.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was not a registered manager who was in day to day control of the service. The manager had resigned shortly before our inspection and the relationship between the manager and provider had deteriorated.

● Prior to our inspection we had been told about the fitting of specialist equipment by an untrained person. This had exposed people to serious risk of harm. In addition, the provider had not ensured that two live in staff were recruited safely. We have reported on both of these issues in the Safe section of this report.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There were limited opportunities for staff or people living at the service to be involved with the running of the service. People had not had regular meetings or forums to give their feedback.

● Staff had not had team meetings or the number of supervisions they should have as set out in the provider's policy.

Quality audits had not been effective in making improvements. People were not supported in a person-centred culture and the provider did not always understand the requirements of their roles. This placed people at risk of poor care outcomes. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The service had been engaging with the local authority. The provider was facilitating reviews from different funding authorities.

● People's confidential information was being used safely and personal data was being protected. The provider told us they were using encrypted services to exchange information with NHS and local authorities. The provider commented, "If those elements are not used, we use initials rather than people's full names."

● Some people had links to the local community. One person attended a local church and other people liked going to the pub. Several people attended day services in the local area.